

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/28/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345302	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/14/2011
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NAME OF PROVIDER OR SUPPLIER MOUNTAIN TRACE REHABILITATION & NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 417 MOUNTAIN TRACE ROAD SYLVA, NC 28779
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F 253 SS=B	<p>483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to maintain cleanliness of wheelchairs for two (2) of seven (7) sampled residents. (Residents #6 and #4).</p> <p>The findings are:</p> <p>1. An observation on 10/14/11 (Friday) at 10:02 AM revealed Resident #6 sitting in a wheelchair. The chair was observed with white colored smears, varying in size, of raised dry debris on rails from armrests to wheels on both sides of the chair. White colored lines were observed on the left wheel of the chair.</p> <p>A review of a wheelchair cleaning schedule revealed Resident #6's wheelchair was scheduled for cleaning on the 11:00 PM to 7:00AM shift on Thursday nights.</p> <p>An interview with Licensed Nurse (LN) #1 was conducted on 10/14/11 at 10:25 AM. At this time Resident #6's wheelchair was observed. LN #1 acknowledged the wheelchair had not been cleaned the night before as scheduled. She stated the chair appeared to contain debris that had been present longer than a day.</p> <p>An interview with the Director of Nursing (DON)</p>	F 253	<p>Plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and or executed solely because it is required by the provisions of Federal and State law.</p> <p><u>Completion date for F-253: 10-18-11</u></p> <p><u>A.</u> Resident's # 4 & 6 had their wheel chairs cleaned on October 14th.</p> <p><u>B.</u> It was determined by an audit that any resident with mobility equipment such as a wheel chair, walker, or cane could be affected by this alleged deficient practice but none were found to be affected.</p> <p><u>C.</u> On Tuesday, Oct. 18th, all mobility equipment was power washed by the Director of Nursing, the Director of Maintenance and the Maintenance Assistant.</p> <p>In-services regarding responsibilities of cleaning of all mobility equipment such as wheel chairs, walkers, & canes were provided for all staff on Sunday, October 16th, Monday, October 17th and Tuesday, October 18th. For those staff unable to attend, they will receive the in-service information prior to their next scheduled work shift. This in-service will also be provided with new staff orientation.</p> <div data-bbox="1071 1543 1380 1711" style="border: 1px solid black; padding: 5px; text-align: center;"> <p>RECEIVED</p> <p>NOV 3 2011</p> <p>APL</p> </div>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Nita Jones ADMINISTRATOR TITLE: _____ DATE: 11/2/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 253	<p>Continued From page 1</p> <p>was conducted on 10/14/11 at 10:38 AM. At this time Resident #6's wheelchair was observed. The Don stated the night shift was expected to follow the schedule posted on each unit for cleaning residents' wheelchairs. The DON stated they should be washed in the shower. She stated her expectation is for residents' equipment to be kept clean.</p> <p>2. On 10/14/11 at 9:51 AM Resident #4 was observed sitting in her wheelchair. The chair was observed to have dry white spills and a build up of fine dust particles covering the rails from the armrests to the wheels on both sides of the chair. Observation of the foot pedals revealed ground in white and dark brown debris covering the entire top surface of both wheelchair pedals.</p> <p>On 10/14/11 at 1:30 PM Resident #4 was observed sitting in her wheelchair. The chair's condition was unchanged.</p> <p>A review of the wheelchair cleaning schedule revealed Resident #4's wheelchair was scheduled for cleaning on 11:00 PM to 7:00AM shift on Sunday night.</p> <p>On 10/14/11 at 1:32 PM the Licensed Nurse Unit Manger was interviewed. She confirmed that wheel chairs on the 200 hall were cleaned on the 11:00 PM to 7:00 AM night shift on Sundays. Resident #4's wheel chair was observed. The Nurse Manger acknowledged the wheel chair was dirtier than if it would have been cleaned on Sunday. She stated the chair appeared to have not been cleaned in awhile.</p>	F 253	<p>A monitoring tool was implemented that certified nurse's aides will sign after the completion of cleaning per schedule. The unit charge nurses will inspect the wheel chairs and co-sign that the mobility was adequately cleaned. The Director of Nursing, the Assistant Director of Nursing, or the Unit Managers will monitor the compliance of these tools and make random observations.</p> <p><u>D.</u> The Director of Nursing will analyze the results of the monitoring tool and report results to the Quality Assurance Committee Meeting monthly for 3 months, then quarterly thereafter to determine the need for additional education and/or monitoring.</p>		
F 441	483.65 INFECTION CONTROL, PREVENT	F 441			

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F 441 SS=D	Continued From page 2 SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441	Plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and or executed solely because it is required by the provisions of Federal and State law. <u>Completion date for F-441: 10-18-11</u> <u>A.</u> Resident #5 remains on Contact precautions with proper signage posted outside room. Personal protective equipment is readily available and placed outside resident's room. <u>B.</u> All residents with special isolation precautions have the potential to be affected by this practice although none were found to be affected.		

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F 441	<p>Continued From page 3</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, medical record review, facility policy, and staff and family interviews the facility failed to implement and monitor facility policy for droplet precautions and ensure mask and gown were worn by staff and visitors for one (1) of one (1) sampled residents on droplet precautions. (Resident #5).</p> <p>The findings are:</p> <p>A facility policy regarding Droplet Transmission Precautions dated 11/15/2002 included the following: Droplet precautions are initiated with residents known to be infected or suspected of being infected with microorganisms transmitted by droplets that can be generated during coughing or sneezing. A gown and a mask must be worn when working within three feet of the resident.</p> <p>Resident #5 was readmitted to the facility 10/07/11 with diagnoses including dysphagia, recurrent aspiration pneumonia, sputum positive for Methicillin resistant staphylococcus aureus (MRSA), and dementia.</p> <p>A review of a microbiology report from the hospital printed on 10/06/11 revealed a sputum specimen was collected from Resident #5 on 10/02/11. The sputum was cultured for the presence of bacteria. A review of the results of a culture dated 10/05/11 revealed positive for growth of MRSA.</p> <p>An observation on 10/14/11 at 12:25 PM revealed</p>	F 441	<p><u>C.</u> Family members, who included the resident's wife and daughter, were educated on the procedure to be followed while the resident is on Contact precautions. Staff was re-educated on the policy and procedures of infection control measures including specific information on following Isolation practices. Any resident's requiring special Isolation precautions will have appropriate signage posted outside rooms with personal protective equipment readily available and visitors will be instructed on proper Isolation practices. The Director of Nursing or Administrator to monitor infection control practices through documented observation of staff and resident family members visiting resident daily x 2 weeks, weekly x 2 weeks then monthly thereafter.</p> <p><u>D.</u> The results of the staff and visitor observations to be presented to the Quality Assurance Committee by the Director of Nursing monthly for 3 months then quarterly thereafter to determine the need for additional education and/or monitoring.</p>		

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F 441	<p>Continued From page 4</p> <p>a sign posted on the wall to the right of the doorway to Resident #5 ' s room. The sign contained the following information: Stop, Droplet Precautions, and Visitors must report to Nursing Station before entering. The sign contained additional information that directed wash hands and wear a mask when entering room. Gowns and a box of mask were observed on a table positioned under the sign. Continued observation revealed a family member without gown or mask sitting in the resident ' s room preparing his meal tray. Resident #5 was observed sitting in a wheelchair with the over bed table containing his lunch tray in front of him. The family member was sitting on the opposite side of the over bed table.</p> <p>An interview with Nursing Assistant (NA) #1 on 10/14/11 at 12:25 PM revealed family members visited Resident #5 daily. She added it was her understanding family members were not required to wear gowns or masks (personal protective equipment) while visiting in Resident #5 ' s room. She continued the family visited daily and had not been wearing any personal protective equipment (PPE).</p> <p>An interview with the family member on 10/14/11 at 12:35 PM revealed she had not been instructed by the facility to wear gown or mask when she visited Resident #5. She stated she does wash her hands before she leaves the room. During the interview, the family member was observed assisting Resident #5 with his meal. Resident #5 was observed coughing with his mouth uncovered during the meal.</p> <p>An interview with the Administrator and DON on</p>	F 441		

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F 441	<p>Continued From page 5</p> <p>10/14/11 at 1:50 PM revealed the Administrator was unaware family members did not wear gown or mask when in Resident #5 's room. The DON stated she was aware family members were not wearing gown or mask. She continued she was unaware family members had to adhere to facility policy regarding droplet precautions when visiting Resident #5. The DON and Administrator stated the family visited only this resident.</p> <p>An interview was conducted via phone on 10/14/11 at 2:08 PM with another family member who frequently visited Resident #5. This family member stated she had observed the sign for droplet precautions by the doorway of Resident #5 's room. She continued the facility had not asked her to wear PPE. The family member stated she goes directly to Resident #5 's room when entering the facility. After the visit, she does not visit any other residents in the facility.</p> <p>An interview with the Administrator was conducted on 10/14/11 at 3:05 PM. She acknowledged to prevent the spread of infection, facility staff and visitors should wear PPE when entering a room designated droplet precautions.</p>	F 441			